



KENTUCKY BOARD OF ALCOHOL AND DRUG COUNSELORS

P.O. Box 1360, Frankfort, Kentucky 40602 ~ 500 Mero St., 2 SC 32, Frankfort, Kentucky 40601
Phone (502) 782-8814 ~ <http://adc.ky.gov>

- APPLICATION FOR:**
- | | |
|--|-----|
| TEMPORARY REGISTRATION AS PEER SUPPORT SPECIALIST | () |
| REGISTRATION AS PEER SUPPORT SPECIALIST | () |
| CERTIFIED ALCOHOL AND DRUG COUNSELOR ASSOCIATE I | () |
| CERTIFIED ALCOHOL AND DRUG COUNSELOR ASSOCIATE II | () |
| TEMPORARY CERTIFICATION AS AN ALCOHOL AND DRUG COUNSELOR | () |
| CERTIFICATION AS AN ALCOHOL AND DRUG COUNSELOR | () |
| CERTIFICATION AS AN ALCOHOL AND DRUG COUNSELOR DEGREED | () |
| LICENSED CLINICAL ALCOHOL AND DRUG COUNSELOR ASSOCIATE | () |
| LICENSED CLINICAL ALCOHOL AND DRUG COUNSELOR | () |
| LICENSED ALCOHOL AND DRUG COUNSELOR | () |

SECTION 1 – APPLICANT INFORMATION

1. _____
Name: First Middle Last Maiden

Social Security Number Date of Birth Home Phone Cell Phone

Mailing Address: Street City State Zip Code

Employer Business Phone

Employer's Address: Street City State Zip Code

Home Email Business Email
2. Have you had a credential in Kentucky or any other state that has ever been suspended or revoked?
☐ YES ☐ NO If yes, give details: _____
3. Have you been convicted of a felony or plead guilty, including an Alford plea (other than minor traffic violations) under the laws of the United States in the last 5 years? ☐ YES ☐ NO If yes, what offense?
_____(If yes, send supporting documentation.)
4. Are you credentialed as an Alcohol or Drug Counselor in any other state? ☐ YES ☐ NO
If yes, what state? _____ Type of Credential? _____
5. Have you ever been discharged or forced to resign for misconduct or unsatisfactory service from any position from any professional training program, or from the program of any university? ☐ YES ☐ NO
(If yes, send supporting documentation.)
6. Have you ever been sanctioned by the Kentucky Board of Alcohol and Drug Counselors or by any other credentialing board or professional associations for ethical misconduct? ☐ YES ☐ NO
(If yes, send supporting documentation.)

7. Are you currently on active military duty? ☐ YES ☐ NO

8. Are you or your spouse a member of the United States military, Reserves, or National Guard, or are you or your spouse a veteran? ☐ YES ☐ NO

If yes, do you currently hold or recently held an equivalent credential issued by another state, the District of Columbia, or any possession or territory of the United States? ☐ YES ☐ NO

If yes, please answer the following questions:

Has your credential issued by another state, the District of Columbia, or any possession or territory of the United States been expired for more than two years? ☐ YES ☐ NO

Is your credential issued by another state, the District of Columbia, or any possession or territory of the United States in good standing? ☐ YES ☐ NO

Has your credential issued by another state, the District of Columbia, or any possession or territory of the United States been suspended for disciplinary reasons? ☐ YES ☐ NO

The United States military service member, Reserves or National Guard member, veteran, or spouse shall submit:

(1) Proof of issuance of a valid license, permit, certificate, or other document issued by another state, the District of Columbia, or any possession or territory of the United States that is active or has been expired for less than two (2) years;

(2) Proof that the valid license, permit, certificate, or other document issued by another state, the District of Columbia, or any possession or territory of the United States is in good standing or was upon the date of expiration; and

(3) His or her DD-214 form or other proof of active or prior military service with an honorable discharge, discharge under honorable conditions, or a general discharge under honorable conditions.

SECTION 2 – APPLICANT EDUCATION

School	Name and Location	Dates Attended	Date of Graduation	Number of Hours	Degree Obtained
High School/Equivalent					
Baccalaureate					
Master's					
Doctoral					

Submit proof of your highest education achieved:

- High school / equivalent - submit a copy of your diploma or certificate.
- Other higher education - submit official transcript sent from registrar of the college or university.

SECTION 3 – WORK EXPERIENCE (Attach Additional Related Experience If Needed)

Name of Employer: _____
Title or Position: _____
Employment Start Date: _____ End Date: _____
Address of Employer: _____
Clinical Supervisor: _____ Credential Number: _____
Total Number of Work Hours per Week Related to Alcohol and Drug Clients: _____
Describe Work Duties Related to Alcohol and Drug Clients: _____

Name of Employer: _____
Title or Position: _____
Employment Start Date: _____ End Date: _____
Address of Employer: _____
Clinical Supervisor: _____ Credential Number: _____
Total Number of Work Hours per Week Related to Alcohol and Drug Clients: _____
Describe Work Duties Related to Alcohol and Drug Clients: _____

AFFIDAVIT

I do hereby certify under penalty of law, that the information contained herein is true, correct and complete to the best of my knowledge and belief. I am aware that, should an investigation at any time disclose such misrepresentation or falsification, my application could be rejected or my certification revoked by the Board. Furthermore, I agree to abide by the standards of practice and code of ethics approved by the Board.

Applicant's Signature (Do not type or print)

Date



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ATTESTATION OF RECOVERY

TEMPORARY REGISTRATION AS PEER SUPPORT SPECIALIST ()

REGISTRATION AS PEER SUPPORT SPECIALIST ()

Pursuant to KRS 309.0831(7), I attest to being in recovery for a minimum of one (1) year from a substance-related disorder.

Signature (Must not be printed or typed)

Date

Printed Name



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PEER SUPPORT SPECIALIST **ALCOHOL / DRUG TRAINING VERIFICATION FORM**

In accordance with 201 KAR 35:050, Section 1 (1), an applicant seeking registration as an alcohol and drug peer support specialist shall complete forty (40) classroom hours, which shall include:

1. Sixteen (16) hours of interactive training in ethics of which eight (8) hours shall consist of face-to-face ethics training;
2. Three (3) hours of domestic violence training;
3. Two (2) hours of training in transmission, control, treatment and prevention of the human immunodeficiency virus;
4. Ten (10) hours of advocacy training;
5. Ten (10) hours of training in mentoring and education; and
6. Ten (10) hours of training in recovery support

(Make as many copies of these pages as needed. Number each page.)

ETHICS TRAINING (16)

Title of Course	Dates of Attendance	Entity Offering Training	No. of Actual Training Hours

Total Number of Hours: _____

HIV TRAINING (2)

Title of Course	Dates of Attendance	Entity Offering Training	No. of Actual Training Hours

Total Number of Hours: _____

MENTORING AND EDUCATION TRAINING (10)

Title of Course	Dates of Attendance	Entity Offering Training	No. of Actual Training Hours

Total Number of Hours: _____**RECOVERY SUPPORT TRAINING (10)**

Title of Course	Dates of Attendance	Entity Offering Training	No. of Actual Training Hours

Total Number of Hours: _____

ADVOCACY TRAINING (10)

Title of Course	Dates of Attendance	Entity Offering Training	No. of Actual Training Hours

Total Number of Hours: _____**DOMESTIC VIOLENCE TRAINING (3)**

Title of Course	Dates of Attendance	Entity Offering Training	No. of Actual Training Hours

Total Number of Hours: _____



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**PEER SUPPORT SPECIALIST
SUPERVISORY AGREEMENT**

To Be Completed By Applicant and Supervisor

INSTRUCTIONS

1. This form is to be used with Microsoft Word.
2. Press the TAB key to skip to the next field.
3. Once you have completed the form, you must print the form, and apply your handwritten signature. Forms submitted without the appropriate signatures will be returned.
4. The completed form may be submitted to the Kentucky Board of Alcohol and Drug Counselors either by mail to P.O. Box 1360, Frankfort, Kentucky 40602 or by delivery to 500 Mero Street, 2SC32, Frankfort, Kentucky 40601.

**SECTION 1
APPLICANT INFORMATION**

First Name	Middle Name	Last Name
/ /	() -	() -
Social Security Number	Home Telephone	Work Telephone
Email Address		
Street Address		
City	State	Zip Code

**SECTION 2
SUPERVISOR INFORMATION**

First Name	Middle Name	Last Name
Email Address		
Street Address		
City	State	Zip Code
() -		
Telephone Number	Type of License/Certification Held and Number	
/ /	/ /	
Date of issue (attach a copy)	Expiration Date (Attach a copy)	

Date of Board Approved Supervision Training (Attach copy of certificate of attendance)	Number of Supervisee's Currently Providing with Board Approved Supervision
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SECTION 3
INFORMATION RELATED TO SUPERVISED EXPERIENCE

Applicant Name _____

Name of organization or agency where experience will be gained (complete a separate form for each setting.)

Street Address of Organization or Agency

City

State

Zip Code

Average number of hours expected to be gained per week: _____

Type of Setting: ☐ State/Government Agency ☐ Hospital
☐ Non-Profit ☐ DUI/Private Practice
☐ School ☐ Rehab Center

Type of peer support/counseling experience to be gained (check all that apply):

☐ Rehabilitation Center ☐ Judicial/Corrections
☐ Child & Adolescent ☐ Individual Counseling
☐ Adult ☐ Group Counseling
☐ Family Treatment
☐ Other

Describe

Describe specifically, and in detail, what work experience will be obtained to meet the criteria for Recovery Support work experience in the four (4) domains: (1) advocacy; (2) ethical responsibility; (3) mentoring and education; and (4) recovery and wellness support. Work experience shall not include counseling. (201 KAR 35:070)

Describe specifically, and in detail, how supervision will focus on recovery support in the four (4) domains: (1) advocacy; (2) ethical responsibility; (3) mentoring and education; and (4) recovery and wellness support.(201 KAR 35:070)

I, as applicant, affirm that all information provided by me on this form is true and accurate and I affirm the following:

- That I have read the board Law and Regulations related to supervised experience and that all supervised experience will be completed in accordance with board rules;
- That I will meet with my supervisor at a minimum of 2 hours twice a month of documented supervised experience;
- That I will abide by all rules of the board, including ethics requirements;
- That I understand the temporary registration or registration is only valid while I practice under supervision;
- That I notify the board if this supervisory arrangement is terminated; and
- That I understand any additional supervisors and settings shall be approved by the board in advance.

Signature of Applicant

Date

Printed Name

This agreement shall not be effective until the board has issued the letter approving the agreement.

I, as the board approved supervisor of the above named applicant, affirm that all information provided by me on this form is true and accurate and I affirm the following:

- That all supervised experience will be completed in accordance with the Law and Regulations related to supervised experience and all subsequent board rules.
- That I will provide supervision to the above name applicant at least 2 hours twice a month of documented experience.
- That I understand the full professional responsibility for services of the supervisee shall rest with the supervisor.
- That I understand the supervisory arrangement is only valid while my credential remains in good standing.
- That I will notify the board if the supervisory arrangement is terminated.
- That I understand that I shall not serve as a supervisor of record for more than twelve persons obtaining experience for peer support/certification/licensure at the same time.

Signature of Supervisor

Date

APPLICANT AND SUPERVISOR SHOULD KEEP A COPY OF THIS FORM FOR RECORDS

BOARD USE ONLY

☐ Approved by _____ Date: _____
(Initials of Reviewer)

☐ Denied by _____
(Initials of Reviewer)

☐ Deferred by by _____ Date: _____
(Initials of Reviewer)



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PEER SUPPORT SPECIALIST **VERIFICATION OF SUPERVISION**

This section must be completed by the applicant and signed by the supervisor. Make as many copies of these pages as needed. Number each page.

Documentation of 25 hours of direct supervision by a Board-Approved Certified Alcohol and Drug Counselor or a Licensed Clinical Alcohol and Drug Counselor must be documented in the four domains: 1. Advocacy; 2. Mentoring/Education; 3. Recovery/Wellness Support; or 4. Ethical Responsibilities. Methods of supervision include: face-to-face, video, or observation.

DATE OBSERVED	Domain Covered	LENGTH OF SESSION	METHOD OF SUPERVISION	SUPERVISOR'S SIGNATURE (Must be legible)

Applicant Name _____

Total Number of Hours _____



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SUPERVISION EVALUATION FOR PEER SUPPORT SPECIALIST

(Completed by each Supervisor)

This form must be entirely completed by each supervisor of qualifying experience. Please pay special attention to the number of hours of direct clinical supervision and percentage of applicant's time allotted to chemical dependency clients.

Applicant's Name _____

Applicant's Address: _____

Clinical Supervisor: _____ Credential Number: _____

Current Address: _____

Date of Issue of Certification: _____ Supervisor's Day Phone Number: _____ / _____ / _____

Program or agency where you supervised the applicant: _____

I have supervised the applicant's work from _____ to _____, which includes approximately
(Date) (Date)
hours of face to face supervision per month for a total of _____ hours.

The approximate percentage of his/her time spent in delivery of services to substance abuse clients: _____%

PERSONAL ATTRIBUTES:

Evaluate the applicant as you observe(d) him/her in the following areas of interpersonal relationship with clients:
(Please use appropriate number as indicated on scale.)

1	2	3	4	5	6
/	/	/	/	/	/
Weak	Fair	Average	Above Average	Superior	NA

- _____ A. Respect for client.
- _____ B. Care and concern for client.
- _____ C. Genuineness with client.
- _____ D. Empathy with client.
- _____ E. Flexibility with client.
- _____ F. Spontaneity with client.
- _____ G. Capacity for appropriate self-disclosure.
- _____ H. Sense of immediacy.
- _____ I. Concreteness.

Applicant's Name _____

Performance Competencies

Evaluate the applicant as you feel he/she demonstrates his/her abilities in the area of recovery support. Mark the rating most nearly descriptive of the applicant's demonstrated skills using the scales given.

1 /	2 /	3 /	4 /	5 /	6 /
Weak	Fair	Average	Above Average	Superior	NA

- _____ A. Advocacy
- _____ B. Ethical Responsibility
- _____ C. Mentoring and Education
- _____ D. Recovery and Wellness Support

PROFESSIONAL AND ETHICAL CONDUCT:

1. Employment of fraud or deception in applying for a registration: ☐ Yes ☐ No. If yes, please comment:
Comment: _____
2. Practicing recovery support or advocacy under a false or assumed name or the impersonation of another credential holder of a like or different name. ☐ Yes ☐ No. If yes, please comment:
Comment: _____
3. Habitual abuse of any mood-altering chemical substance to such an extent as to interfere consistently with the competent performance of his/her duties. ☐ Yes ☐ No. If yes, please comment:
Comment: _____
4. Misrepresentation of one's professional credentials: ☐ Yes ☐ No. If yes, please comment:
Comment: _____
5. Failure to adhere to KRS 309.080 to 309.089: ☐ Yes ☐ No. If yes, please comment:
Comment: _____

Describe what you believe to be significant strengths and / or deficiencies of the applicant (attach additional pages, if needed):

I recommend _____ for registration as a peer support specialist.
Applicant's Name

I do not recommend _____ for registration as a peer support specialist.
Applicant's Name

Signature: _____ Credential: _____

Current Address: _____

Date Signed: _____